FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039263

Facility Name: Shady Oaks East

Address: 16240 Parker Road (Number) Lockport, IL (City) 60441 (Zip Code)

County: Will

Telephone Number: (708) 301-6870 **Fax #** (708) 301-6878

IDPA ID Number: 36-2584799-036

Date of Initial License for Current Owners: 1994

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Erica Mazurowski **Telephone Number:** (847) 635-4648

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,110			5,110	13
14	TOTALS	5,110			5,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.50%

D. How many bed-hold days during this year were paid by Public Aid?
220 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/17/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date Jan 1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	41,811	1,595	2,396	45,802		45,802		45,802			1
2	Food Purchase		23,226		23,226		23,226		23,226			2
3	Housekeeping		22,008	211	22,219		22,219		22,219			3
4	Laundry		574	105	679		679		679			4
5	Heat and Other Utilities			11,873	11,873	726	12,599		12,599			5
6	Maintenance	13,140	2,419	9,374	24,933	1,353	26,286		26,286			6
7	Other (specify):* Rubbish Removal			1,581	1,581	308	1,889		1,889			7
8	**TOTAL General Services**	54,951	49,822	25,540	130,313	2,387	132,700		132,700			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	344,900	5,327	138,456	488,683		488,683		488,683			10
10a	Therapy											10a
11	Activities		67		67		67		67			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	344,900	5,394	140,456	490,750		490,750		490,750			16
	C. General Administration											
17	Administrative	24,733			24,733	148,605	173,338		173,338			17
18	Directors Fees											18
19	Professional Services			319,896	319,896	(236,415)	83,481	4,656	88,137			19
20	Dues, Fees, Subscriptions & Promotions			2,922	2,922	6,737	9,659		9,659			20
21	Clerical & General Office Expenses	26,557	2,480	16,926	45,963	15,060	61,023		61,023			21
22	Employee Benefits & Payroll Taxes			81,347	81,347	22,260	103,607		103,607			22
23	Inservice Training & Education					1,550	1,550		1,550			23
24	Travel and Seminar			4,491	4,491		4,491	(129)	4,362			24
25	Other Admin. Staff Transportation			449	449	4,015	4,464		4,464			25
26	Insurance-Prop.Liab.Malpractice			4,282	4,282	4,271	8,553		8,553			26
27	Other (specify):* Unallowable Advertising & Promotion					1,036	1,036	(1,036)				27
28	**TOTAL General Administration**	51,290	2,480	430,313	484,083	(32,881)	451,202	3,491	454,693			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	451,141	57,696	596,309	1,105,146	(30,494)	1,074,652	3,491	1,078,143			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shady Oaks East #0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,239	13,239	10,966	24,205	12,810	37,015			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,898	2,898	3,129	6,027	19,610	25,637			32
33	Real Estate Taxes					59	59		59			33
34	Rent-Facility & Grounds			47,085	47,085	15,091	62,176	(44,085)	18,091			34
35	Rent-Equipment & Vehicles			1,141	1,141	1,249	2,390		2,390			35
36	Other (specify):*											36
37	**TOTAL Ownership**			64,363	64,363	30,494	94,857	(11,665)	83,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			209,173	209,173		209,173	1,253	210,426			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,049	55,049		55,049		55,049			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			264,222	264,222		264,222	1,253	265,475			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	451,141	57,696	924,894	1,433,731		1,433,731	(6,921)	1,426,810			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(602)	30		9
10	Interest and Other Investment Income	(296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,036)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	5,221			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,287		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,208)	34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,208)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,921)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Shady Oaks East

ID# 0039263

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust out prior year transaction	$ 1,253	39	1
2	Adjust out prior year transaction	(129)	24	2
3	Adjust in allowable from Management Allocation	22,057	19	3
4	Adjust out unallowable from HR Allocation	(3)	19	4
5	Adjust out unallowable from Serv. Net Allocation	(17,952)	19	5
6	Adjust in allowable from Local Admin. Allocation	554	19	6
7	Adjust out management auto depreciation	(559)	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	5,221		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Shady Oaks East # 0039263 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	4,656	0	0	0	0	0	0	0	0	0	0	4,656	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(129)	0	0	0	0	0	0	0	0	0	0	(129)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,036)	0	0	0	0	0	0	0	0	0	0	(1,036)	27
28	**TOTAL General Administration**	3,491	0	0	0	0	0	0	0	0	0	0	3,491	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,491	0	0	0	0	0	0	0	0	0	0	3,491	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks East # 0039263 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,161)	13,971	0	0	0	0	0	0	0	0	0	12,810	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(296)	19,906	0	0	0	0	0	0	0	0	0	19,610	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(10,208)	(44,085)	0	0	0	0	0	0	0	0	0	(54,293)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,665)	(10,208)	0	0	0	0	0	0	0	0	0	(21,873)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	1,253	0	0	0	0	0	0	0	0	0	0	1,253	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	1,253	0	0	0	0	0	0	0	0	0	0	1,253	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,921)	(10,208)	0	0	0	0	0	0	0	0	0	(17,129)	45

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		Vesper Mgmt Corp.	Des Plaines, IL	Mgmt Co.
				Lutheran Social Servic	Des Plaines, IL	Corporate Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental of Facility	$ 44,085	Vesper Management Corp	100.00%	$	$ (44,085)	1
2	V	32	Interest		Vesper Management Corp	100.00%	19,906	19,906	2
3	V	30	Depreciation		Vesper Management Corp	100.00%	13,971	13,971	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 44,085			$ 33,877	$ * (10,208)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Cost	27,031,134	270	$ 1,056,638	$ 1,056,638	566,340	$ 22,138	1
2	22	Empl Benefits & Taves		27,031,134		218,957		566,340	4,587	2
3	19	Prof Fees & Contracts		27,031,134		3,715,943		566,340	77,854	3
4	21	Supplies, Telephone,		27,031,134		535,066		566,340	11,210	4
5		Postage, Out. Printing		27,031,134		0		566,340	0	5
6	34	Rental of Space		27,031,134		326,694		566,340	6,845	6
7	5	Utilities		27,031,134		31,566		566,340	661	7
8	6	Bldg Repair & Maintenance		27,031,134		0		566,340	0	8
9	32	Interest		27,031,134		82,750		566,340	1,734	9
10	33	Real Estate Taxes		27,031,134		2,822		566,340	59	10
11	26	Insurance		27,031,134		151,003		566,340	3,164	11
12	27	Advertising & Promotions		27,031,134		49,466		566,340	1,036	12
13	25	Transportation		27,031,134		47,462		566,340	994	13
14	35	Car Rental		27,031,134		5,970		566,340	125	14
15	23	Conferences & Conventions		27,031,134		51,384		566,340	1,077	15
16	20	Subscriptions, Dues, Awards		27,031,134		64,835		566,340	1,358	16
17	21	Furniture & Fixtures		27,031,134		1,593		566,340	33	17
18	6	Machinery & Equipment		27,031,134		182		566,340	4	18
19	35	Equipment Rental		27,031,134		36,059		566,340	755	19
20	6	Equipment Repair & Maint.		27,031,134		40,926		566,340	857	20
21	20	Employee Recruitment		27,031,134		28,122		566,340	589	21
22	7	Security & Waste Removal		27,031,134		12,918		566,340	271	22
23	21	All Other Miscellaneous		27,031,134		4,405		566,340	92	23
24	30	Depreciation		27,031,134		337,778		566,340	7,077	24
25	TOTALS					$ 6,802,539	$ 1,056,638		$ 142,520	25

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	44,347,970	270	$ 730,935	$ 730,935	532,906	$ 8,783	1
2	22	Empl Benefits & Taves		44,347,970		96,673		532,906	1,162	2
3	19	Prof Fees & Contracts		44,347,970		123,952		532,906	1,489	3
4	21	Supplies, Telephone,		44,347,970		44,417		532,906	534	4
5		Postage, Out. Printing		44,347,970				532,906		5
6	34	Rental of Space		44,347,970		7,359		532,906	88	6
7	5	Utilities		44,347,970		409		532,906	5	7
8	6	Bldg Repair & Maintenance		44,347,970		577		532,906	7	8
9	32	Interest		44,347,970		4,700		532,906	56	9
10	33	Real Estate Taxes		44,347,970				532,906		10
11	26	Insurance		44,347,970		888		532,906	11	11
12	27	Advertising & Promotions		44,347,970				532,906		12
13	25	Transportation		44,347,970		22,753		532,906	273	13
14	35	Car Rental		44,347,970		2,024		532,906	24	14
15	23	Conferences & Conventions		44,347,970		8,477		532,906	102	15
16	20	Subscriptions, Dues, Awards		44,347,970		208,557		532,906	2,506	16
17	21	Furniture & Fixtures		44,347,970		22		532,906		17
18	6	Machinery & Equipment		44,347,970				532,906		18
19	35	Equipment Rental		44,347,970		9,388		532,906	113	19
20	6	Equipment Repair & Maint.		44,347,970		2,201		532,906	26	20
21	20	Employee Recruitment		44,347,970		18,345		532,906	220	21
22	7	Security & Waste Removal		44,347,970		81		532,906	1	22
23	21	All Other Miscellaneous		44,347,970		4,517		532,906	54	23
24	30	Depreciation		44,347,970		18,595		532,906	223	24
25	TOTALS					$ 1,304,870	$ 730,935		$ 15,677	25

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Cost	4,641,682	88	$ 630,313	$ 630,313	566,340	$ 76,906	1
2	22	Empl Benefits & Taves		4,641,682		78,313		566,340	9,555	2
3	19	Prof Fees & Contracts		4,641,682		58,894		566,340	7,186	3
4	21	Supplies, Telephone,		4,641,682		20,075		566,340	2,449	4
5		Postage, Out. Printing		4,641,682				566,340		5
6	34	Rental of Space		4,641,682		45,702		566,340	5,576	6
7	5	Utilities		4,641,682		517		566,340	63	7
8	6	Bldg Repair & Maintenance		4,641,682		474		566,340	58	8
9	32	Interest		4,641,682		2,925		566,340	357	9
10	33	Real Estate Taxes		4,641,682				566,340		10
11	26	Insurance		4,641,682		8,012		566,340	978	11
12	27	Advertising & Promotions		4,641,682				566,340		12
13	25	Transportation		4,641,682		14,541		566,340	1,774	13
14	35	Car Rental		4,641,682		1,843		566,340	225	14
15	23	Conferences & Conventions		4,641,682		3,014		566,340	368	15
16	20	Subscriptions, Dues, Awards		4,641,682		12,583		566,340	1,535	16
17	21	Furniture & Fixtures		4,641,682				566,340		17
18	6	Machinery & Equipment		4,641,682				566,340		18
19	35	Equipment Rental		4,641,682		37		566,340	5	19
20	6	Equipment Repair & Maint.		4,641,682		2,823		566,340	344	20
21	20	Employee Recruitment		4,641,682		1,905		566,340	232	21
22	7	Security & Waste Removal		4,641,682		291		566,340	36	22
23	21	All Other Miscellaneous		4,641,682		(143)		566,340	(17)	23
24	30	Depreciation		4,641,682		23,896		566,340	2,916	24
25	TOTALS					$ 906,015	$ 630,313		$ 110,546	25

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
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Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Cost	4,281,142	51	$ 308,254	$ 308,254	566,340	$ 40,778	1
2	22	Empl Benefits & Taves		4,281,142		52,581		566,340	6,956	2
3	19	Prof Fees & Contracts		4,281,142		444		566,340	59	3
4	21	Supplies, Telephone,		4,281,142		5,266		566,340	697	4
5		Postage, Out. Printing		4,281,142				566,340		5
6	34	Rental of Space		4,281,142		19,521		566,340	2,582	6
7	5	Utilities		4,281,142		(23)		566,340	(3)	7
8	6	Bldg Repair & Maintenance		4,281,142		4		566,340	1	8
9	32	Interest		4,281,142		7,426		566,340	982	9
10	33	Real Estate Taxes		4,281,142				566,340		10
11	26	Insurance		4,281,142		893		566,340	118	11
12	27	Advertising & Promotions		4,281,142				566,340		12
13	25	Transportation		4,281,142		7,360		566,340	974	13
14	35	Car Rental		4,281,142		14		566,340	2	14
15	23	Conferences & Conventions		4,281,142		23		566,340	3	15
16	20	Subscriptions, Dues, Awards		4,281,142		94		566,340	12	16
17	21	Furniture & Fixtures		4,281,142				566,340		17
18	6	Machinery & Equipment		4,281,142				566,340		18
19	35	Equipment Rental		4,281,142				566,340		19
20	6	Equipment Repair & Maint.		4,281,142		425		566,340	56	20
21	20	Employee Recruitment		4,281,142		2,153		566,340	285	21
22	7	Security & Waste Removal		4,281,142		2		566,340		22
23	21	All Other Miscellaneous		4,281,142		61		566,340	8	23
24	30	Depreciation		4,281,142		5,667		566,340	750	24
25	TOTALS					$ 410,165	$ 308,254		$ 54,260	25

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax-Exempt Bonds		X	Construction of Facility	N/A	9/23/93	$ 556,921	$ 242,582	8/15/20	0.0738	$ 22,804	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Alloc (per Sch VIII's)	X		N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,129	6
7												7
8												8
9	TOTAL Facility Related						$ 556,921	$ 242,582			$ 25,933	9
	B. Non-Facility Related*											
10	Interest Income			Interest Income Offset	N/A	N/A	N/A	N/A	N/A	N/A	(296)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (296)	14
15	TOTALS (line 9+line14)						$ 556,921	$ 242,582			$ 25,637	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks East COUNTY Will

FACILITY IDPH LICENSE NUMBER 0039263

CONTACT PERSON REGARDING THIS REPORT Erica Mazurowski

TELEPHONE (847) 635-4648 FAX #: (847) 635-6764

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ N/A	$ N/A

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,673 B. General Construction Type: Exterior Face Brick/Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1993	$ 558,820	$ 13,971	40	$ 13,971	$	$ 104,798	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1994	13,969	1,401	10	1,397	(4)	9,086	9
10	Electrical System			1994	775	77	10	78	1	504	10
11	Septic Tank			1995	2,100	210	10	210		1,155	11
12	Norwalk Tank			1998	20,585	515	40	515	(0)	1,716	12
13	Flooring			1999	15,803	1,587	10	1,580	(7)	3,810	13
14	Shower Trolley			1999	3,839	547	7	548	1	867	14
15	Replacement of Srinkler System			2001	5,750	142	10	142		142	15
16											16
17	Management Assets - Security System			1999	115		10	26	26	N/A	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 84,609	$ 3,789	$ 13,435	$ 9,646		$ 10,278	71
72	Current Year Purchases	19,057	1,550	2,290	740		1,550	72
73	Fully Depreciated Assets	15,977					15,977	73
74								74
75	TOTALS	$ 119,643	$ 5,339	$ 15,725	$ 10,386		$ 27,805	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residential Transportation	1995 Cheverolet G-Van	1994	$ 19,776	$ 3,422	$ 2,824	$ (598)	7	$ 18,368	76
77										77
78										78
79										79
80	TOTALS			$ 19,776	$ 3,422	$ 2,824	$ (598)		$ 18,368	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 761,175	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,211	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,015	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,804	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 168,251	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1987 Dodge Caravan 1987	$ 12,800	$	$ 12,800	86
87					87
88	Management Auto	4,780	559	N/A	88
89					89
90					90
91	TOTALS	$ 17,580	$ 559	$ 12,800	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,141 Description: Water Cooler & Copy Machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ N/A	$ N/A	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ N/A	$ N/A	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ N/A	$ N/A	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ N/A	$ N/A	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ N/A	$ N/A	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ N/A	$ N/A	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ N/A	$ N/A	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ N/A	$ N/A	46
47	**TOTAL EQUITY(page 18, line 24)**	$ N/A	$ N/A	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ N/A	$ N/A	48

***(See instructions.)**

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ N/A	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ N/A	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ N/A	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ N/A	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ N/A	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 862,372	1
2	Discounts and Allowances for all Levels	17,127	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 845,245	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	50,000	24
25	Interest and Other Investment Income***	296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50,296	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Day Training**	209,173	28
28a	**Food Service & Equipment Refund**	100	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 209,273	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,104,814	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	130,313	31
32	Health Care	490,750	32
33	General Administration	484,083	33
	B. Capital Expense		
34	Ownership	64,363	34
	C. Ancillary Expense		
35	Special Cost Centers	209,173	35
36	Provider Participation Fee	55,049	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,433,731	40
41	**Income before Income Taxes (line 30 minus line 40)****	(328,917)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (328,917)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	2,145	2,389	37,477	15.69	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,177	1,346	19,290	14.33	13
14	Head Cook	2,315	2,444	22,521	9.21	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	946	1,065	13,141	12.34	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,019	1,093	24,733	22.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,975	2,277	26,557	11.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	369	376	5,789	15.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,573	28,406	301,633	10.62	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	35,519	39,396	$ 451,141 *	$ 11.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 1,581	1,3	35
36	Medical Director	As Needed	2,000	9,3	36
37	Medical Records Consultant	As Needed	126	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	2,425	10,3	39
40	Physical Therapy Consultant	As Needed	378	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) See Attached	As Needed	2,371	Various	46
47	Developmental Training	As Needed	209,173	39,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 218,054		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	As Needed	8,793	10,3	51
52	Nurse Aides	As Needed	125,308	10,3	52
53	TOTAL (lines 50 - 52)		$ 134,101		53

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristin Salinas	Pgm Director	0	$ 24,733
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 24,733

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Claudon, Lloyd, Barnhart	Legal	$ 1,098
John Satter	Legal	170
Freeman, Freeman & Salzman	Legal	281
LSSI	Management Services	318,347
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 319,896

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,293
Unemployment Compensation Insurance	4,286
FICA Taxes	33,526
Employee Health Insurance	40,314
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension	(4,447)
Employee Physicals	375
Management Allocation (per Sch VIIIs)	22,260
TOTAL (agree to Schedule V, line 22, col.8)	$ 103,607

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,704
Health Care Worker Background Check	0
(Indicate # of checks performed)	0
Membership Dues	18
Management Allocation (per Sch VIIIs)	6,737
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,659

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	2,792
Employee Mileage Payments	1,074
Other Travel Expense	(129)
Seminar Expense	625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,362

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shady Oaks East # 0039263 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,829 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 55,049
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Clifton Gunderson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. In progress, will send ASAP

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.